Psychiatric Information for General Practice

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IT IS IMPERATIVE that a physician bear in mind that to his patients he is a very significant and emotionally highly charged figure. By the nature of his unique position in society a physician has great impact on the patient, either positively or negatively, rightly or wrongly. Almost anyone in our social structure remembers that from childhood on it was the physician who was called when the family was in trouble and the parents were frightened. This gave him great power in the eyes of the child, and the impression lives on in the unconscious mind of the adult.

The First Interview

Another basic consideration is the form and the content of the initial interview. It is required that the physician pay strict and respectful attention to the patient's history and to his behavior. Reactions to the patient's complaints must not be flippant, casual or neglectful. Writing extensive notes during the interview is proscribed; lest it seem to the patient that the physician, busy writing, is listening with but half an ear. Above all, one should not attempt to fill out a form in the first part of the first interview. I have seen many patients who would never return to a physician who started out questioning them and filling out a form. They felt, and I believe they were right, that he was more interested in record-keeping than he was in their suffering. One can get around to filling out the form later in the interview or at another interview.

In the first interview it is essential to appraise the patient's condition. Appraisal means more than merely establishing a diagnosis. Appraisal should try for the answer to the primary question: Is the condition that is to be dealt with static or chronic, or are there signs of progressing decompensation and loss of equilibrium. The entire plan of procedure depends on the answer to this question. As long as the patient is in some state of equilibrium, neurotic or psychotic though it may be, there is time to see the patient several times and to reach conclusions deliberately. If, however, there are signs that the condition may be the beginning of acute decompensation, whether psychotic or neurotic, it is imperative to recognize the prospect, for patients in such circumstances require specialized treatment. It is true that the general physician who appraises the patient may have to do the emergency first aid work (which is to be discussed later) but, by and large, acute decompensating neuroses or psychoses ought to be treated by specialists.

The crucial issue in determining whether or not one is dealing with acute decompensation or with a patient who has achieved and maintained some equilibrium has to do with the relationship between the patient's control apparatus and his impulses. If during the interview it is observed that the impulse-control balance is shifting toward impulsivity—that is, that the patient is pouring out material, unable to stop and losing control over his thinking and judgment—then the physician has to change the nature of the interview, must assume control of the situation. Instead of passively listening to the patient or encouraging the patient in very general terms to tell his story, the physician ought to intervene and ask specific questions or change the subject, or even tell the patient it is best now to stop talking for the nonce, while some other aspect of the examination is carried out. Above all, when the patient seems to be losing control, one ought to stop probing questions of any kind.

If the physician determines in the interview that the controls of the patient are strong enough to contain the impulsive elements, then it is permissible to ask questions for a deeper understanding of the problem. By and large, however, the best information is obtained if one follows the leads of the patient, doing as little specific questioning as possible. The patient's way of relating to this relatively unstructured situation often indicates how well or poorly his ego is functioning. There is a great deal more to the appraisal of the patient in the initial interview, but not all the factors can be dealt with in so brief a presentation.

Another question, however, which has to be answered in the initial interview or interviews is: Is this patient treatable by me, or not? This is partly determined by the state of equilibrium or lack of equilibrium, and also by the diagnostic appraisal. However, the answer is complicated by the fact that one must consider what method of treatment is available to this patient. Even though the case may be one of chronic neurosis and very difficult to treat, if the patient is unable for one reason or another to go to a psychiatrist, it may become necessary for the general physician to take over the treatment. Here, too, not only the diagnosis but the patient's motivations, the patient's resources, the availability of psychiatric help, all will play a determining role in whether or not the patient should be referred to a

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psychiatrist or treated by the physician who confronts him first.

Another matter for consideration with regard to the form and content of the initial interviews is the importance of giving the patient enough time. Effective psychotherapy takes time. Not that it is necessary to give a patient a full hour at each interview, but establishing rapport and a working relationship cannot be done with any appearance of haste. In this regard, it is imperative that the physician not be interrupted by telephone calls or questions from office personnel during an interview with a patient. An important factor in dealing with a psychiatric patient is the recognition that the more emotional discharge he gets in telling his story, the more he will feel relieved. Since it is the amount of emotion he is able to discharge in the telling that has therapeutic effect, if a patient is reciting his woes in a monotonous long-drawn manner, it may be wise to gently point this out to him in an attempt to encourage him to reveal his true underlying emotions. Often this is not an easy job, and it may be impossible. Nevertheless, if the therapist asks about the lack of emotion, the patient's response to this stimulus may make it possible for him to have some emotional catharsis in the interview.

The Physician's Demeanor

A physician must give thought to his manner of paying attention and to his own emotional responses to the patient. His face ought to reflect, at least in quality, the physician's sympathy and empathy with the sufferings of the patient. One ought to permit one's face to have the ordinary human reactions of an interested, involved and yet objective observer. The deadpan is completely out of place in any form of psychotherapy. A physician ought not treat unless he has a sense of security in the treatment. A frightened physician is a poor therapist, particularly in psychiatric problems. If the physician feels the patient is too sick for him to handle, or is too disturbing for other reasons, he ought to refer the patient elsewhere. I do not believe that a physician who is himself insecure can effectively treat emotionally disturbed patients.

The Anxious Patient

It is the therapist's task to provide the patient with an atmosphere of acceptance, empathy and security. An anxious patient needs time and encouragement to express his anxieties. The more thoroughly he describes his fears in the greatest detail and with all the appropriate emotion, the more relieved he will feel, particularly if the therapist's attitude is understanding and unafraid. It is crucial that the therapist give him undivided attention and respect the nature of his troubles. One must remember that quick reassurances given before a careful study of the patient are usually worthless—in fact damaging. In order for reassurance to be lastingly effective, it must be given only after a careful hearing and serious study of the prob'em, as an indication that all the possibilities are weighed.

The more realistic and simple the reassurance, the more effective it will be. Reassurance which is overdone is empty and may produce anxiety. Sometimes it is necessary to withhold giving reassurance until one has gathered sufficient material. The patient may temporarily feel anxiety but later, when reassurance at last is given, it will be much more effective.

It is very important never to reassure a patient falsely. If the therapist does not feel the situation is encouraging, it is better to say nothing than to give false reassurance. Psychiatric patients are unusually keen and sensitive in picking up the physician's anxiety. It is much better for the physician to say that he is not sure about the situation than to reassure when he has doubt and misgivings. It is better in such circumstances for the therapist to tell a patient that he does not completely understand the nature of the patient's problem and will need more time.

The Depressed Patient

A depressed patient does not respond well to a happy-go-lucky, cheerful attitude on the part of the physician. It is important to realize that a depressed person is full of internalized hostility which he is unable to properly discharge. By and large, depressed people hate themselves. If the physician is cheerful and gentle with a depressed patient, the patient may think "What a wonderful doctor!"—and hate himself the more. Depressed patients need, first of all, someone who appears to be stronger than they are. They must feel quite certain they cannot destroy the therapist with their hostility and misery.

They also need someone who they believe can understand the nature of their problem. It is very helpful to talk to depressed patients in a tone of voice which resembles some of the internal voices that are going on within them. I have found it very useful to talk with severely depressed patients in a somewhat gruff tone of voice. I think they hear this tone and will pay attention to it, for it is the way they have been talking to themselves. It is, however, important that the patient realize that the physician is not angry with him, but angry with the way he mistreats himself.

It is important to remember that at certain times depression is a normal reaction. Patients who have

recently lost a beloved wife or a member of the family will often go through a period of grief and mourning. This may last days, weeks and even months and is not necessarily pathological; in fact it is to be encouraged. Only healthy people can really cry and mourn the loss of someone they love; sick people can't cry. It is only when the depression goes on beyond a few months and into years, and there is no crying, that the depression can be considered pathological. It is important to realize that life is often full of miserable occurrences. Psychotherapy does not always have the aim to make life beautiful but can sometimes only try to make life more bearable. There are lots of real miseries that psychotherapy cannot cure.

Elderly Patients

One of the basic necessities in dealing with an elderly patient is for the physician to be able to get the patient to talk about his fear of death. It is important for patients to realize that everyone who thinks about death fears it and that it is a perfectly natural fear. Nevertheless, it is also important to realize that the conception of death is often confused in people's minds with lots of other fearful and frightening experiences. With many persons the fear of death is associated with old ideas about bodily mutilation or childhood ideas of purgatory and punishment. It is very valuable to discuss with patients their fear of death and to help deconfuse them about it. They will often project onto the conception of death and condense it with lots of childhood fears, the fear of unconsciousness, the fear of God's punishment and the like.

Many older people, well in their sixties, respond quite well to psychotherapy. The notion that a man of sixty is rigid and untreatable is not true. I have found many patients in their sixties much more flexible, changeable and influenceable than some persons in their twenties and thirties. It is also important to realize that people at this age need to be active, to participate in things which concern them and are important to them. I think it is nonsense to give them all kinds of pseudo-activities—like bird-watching, say, if they are not interested in birds. A 65-year-old man who has always been active in community affairs or is interested in literature ought to be encouraged to actively continue his work. Older people should do what really interests them, even if it is hard work. Enforced taking-it-easy and enforced retirement is extremely dangerous for the older patient. Participating in something useful and gainful and constructive means being a member of the world, and that means living. Many older people have been forced into part-time living by well-meaning relatives and friends.

Marital Advice

Another area of great importance for the psychiatrically oriented general physician has to do with the giving of marital advice. In this delicate field it is very easy to make mistakes by going to extremes in any of several directions. It is necessary to realize that the marital partners who are coming to the physician are usually anxious, embarrassed and frightened. It is the physician's task to put them at their ease; but it is important not to do so by being either sexy in approach, or puritanical. There is a proper dignity and familiarity in dealing with such problems which must be conveyed to these patients. One reassures them and puts them at their ease by talking to them openly and yet with a sense of delicacy.

In talking about sexual matters, it is important not only to educate the patients in pertinent physiology and anatomy but also as to the emotional aspects of the sexual relationship. Here, too, one has to be careful neither to glorify sex and make it the paramount aspect of life or to devaluate it as merely another physiological reflex which needs to be executed at periodic intervals.

The patient also ought to be made aware of fluctuations, normal fluctuations, in sexuality and in responsiveness. They ought to know it takes time to find one's way with oneself sexually as well as with one's partner's sexuality. One ought to give these people a rather broad conception of sexual practices without either encouraging them to experiment beyond their psychological ability or admonishing them to adhere strictly to certain conventional concepts. Again openness and delicacy as well as education are necessary. Above all, they must be made to understand that sexuality is for emotional and sensual pleasure and not a duty, a sin or a reflex. Young people need time to become familiar with their own bodies and sexual responses and with the bodies and sexual responses of their partners.

Frigidity and Impotence

In dealing with problems of frigidity and impotence, it is necessary to differentiate between cases of long standing, in which the problem is deep seated and very resistant, and cases which may have a simpler structure. By and large, I would not do extensive probing in such cases. I would permit the patient to set the pace and see how much he is able to communicate and how much understanding he has for his particular problem. When there is great resistance to talk, I would not push. I feel those are the problems that probably require special handling. I would make sure that I do not give the impression that the existence of impotence or frigidity means a marriage is doomed. I would also make sure that the

patient know that, by and large, impotence and frigidity are curable disorders. The therapist's line of questioning ought to go in the direction of finding out if some recent event started the difficulty (if so, perhaps simple catharsis about the recent event might uncover the unconscious need to be frigid or impotent) or if perhaps lack of education and timidity are at the bottom of the trouble and might be dealt with by education and reassurance. One should be very careful, however, about complicating matters by proceeding too deeply and too quickly with these patients. In general, if the problem has existed for a long time and there is great reluctance to talk about it, referral to a psychiatrist would seem the best course. The way to do this, however, is not to make it a matter of life and death, for that will frighten the patient. In cases of frigidity and impotence which are of only recent development and the patient is not reluctant to talk, a general physician might well encourage him to talk and see whether this talk and the education the physician can give is helpful. Patients who do not respond in a few months should be prepared and educated for seeking psychiatric consultation.

Obesity

In my opinion obesity has become a national problem. In America we tend to overeat, overdrink, oversmoke and overtalk. It seems as though we are becoming a rather orally fixated nation. There are different kinds of emotional obesity problems and we ought to distinguish between benign obesity and the more severe forms of emotional obesity. The severe forms are certainly not in the province of general physicians and are extremely difficult to treat even for the most skillful specialists. The severe forms are those in which overeating has become an addiction and alternates with bouts of deep depression and has led to severe impairments in major fields of endeavor.

The more benign obesity problems can be dealt with by general physicians. Many persons constantly overeat, as a form of consolation for some recently experienced disappointment or frustration. It may be noted that some persons will overeat after an unhappy love affair or blow to the self-esteem. Getting them to recognize this connection can be helpful. It is wise of course to make sure that obesity does not stem from organic factors before delving into the emotional elements. As to obesity in a patient who consults a physician for something else, there is little that can be done about the excess of weight unless he becomes interested in the problem and wants to do something about it.

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Psychosomatic Medicine

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I SHOULD LIKE to begin by first highlighting some of the theoretical considerations relevant to the dynamics of the psychosomatic process, then to follow this with an excursion into some typical clinical examples, and finally a consideration of certain practical applications.

The human impulse, seeking discharge, may find one of three alternate paths: It can be discharged into action, that is, the person *does* something; or into affects—the discharge is into the *interior* of the organism and the person *feels* something; or into thought, in which the impulse is partially bound and partially discharged, but at any rate dealt with in a certain way, and the person *thinks* something. These are in the main the derivative end-products of instincts with which we deal in our daily efforts to assess a human being, his thoughts, his actions and his feelings.

In the situation of psychic conflict, such as prevails at the core of any neurosis, there are specific defenses against the impulses, with attendant inhibitions of discharge, from which various distortions and resultant end-products can obtain. These can be either directed externally, resulting in abnormal external actions of various degrees and types, which constitute the *behavior* problems discussed elsewhere in this symposium, or the effects can be internal. Of the latter, there may eventuate, from this internalization, some kind of abnormal mental phenomenon, such as a compulsion or an obsession, or a pathological affect or mood such as a depression; or what might result is a pathological end-product in the somatic sphere. It is this last eventuality which comprises our focus of interest—the psychosomatic sequelae of neurotic conflict.

It is well to point out that the term *psychosomatic* implies a duality which in fact does not exist, for there is in reality no small and discreet group of somatic diseases psychically induced, but rather a spectrum of diseases, with both organic and psychological factors operative in all, but more of one or the other at each end of this spectrum. Thus, in one of the definitive papers written on this subject in 1945, Otto Fenichel uses the word *so-called* (psychosomatic phenomena) in the title, pointing to and correcting this inconsistency and loose usage. Although there is this spectrum, with organicity and psychogenicity at each end, one is hard put to think

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